§46.1 GUIDELINES FOR THE EVALUATION OF FOOT AND ANKLE DISABILITY

I. INTRODUCTION

A. BASIC PURPOSE OF THE GUIDELINES

The purpose of these evaluation guidelines is to develop a more uniform method of evaluating foot and ankle injuries without diminishing the individual expertise of the participating evaluator. This method will allow involved parties (particularly the WCAB) to review evaluator's reports which employ a more standardized format.

B. GENERAL APPROACH

The evaluator shall personally take the history from the injured worker and perform the examination. The evaluator may have an assistant make an initial outline of the injured worker's history or take excerpts from prior medical records, however the evaluator must review the excerpts and/or outline with the injured worker. Occupational and medical questionnaires may be useful to assist the injured worker in compiling the details of the injury prior to the consultation with the evaluator. Any discrepancies in the various sources of information should be identified and clarified by the evaluator.

The injured worker shall at all times be evaluated in a compassionate and respectful manner.

The evaluator ~~will~~ should introduce him/herself, and explain to the injured worker the purpose and scope of the evaluation.

The evaluator must inform the injured worker of any significant medical findings, which could impact on his or her health. These findings may not be directly related to the work injury.

II. COMPONENTS OF THE REPORT

A. INITIAL PAGE

Address the report to the referring party(ies) or the DEU office noted on the Request for Summary Rating form. Report on the face to face time and factors influencing the complexity of the examination, being aware that complexity factors may be medical in nature or medical-legal, such as apportionment.

Give names and professional description of any persons assisting with the report or performing diagnostic or consultative services. Note if there were communication difficulties (e.g. aphasia) or translation services required for the evaluation.

~~D.~~ B. History

Medical records and history questionnaires shall be used only as an adjunct to the history as told by the patient to the physician. The physician shall personally take the history from the injured worker. Any discrepancies in the history between various sources must be identified and clarified. An appropriate history shall include:

(1) Work history, including previous and current jobs, and some description of previous, and current job duties. Review and comment on a formal job description if it is available for review. Particular attention for the foot and ankle is placed on requirements for standing, walking (over even or uneven surfaces), running, squatting, sitting, kneeling, climbing, jumping, hopping, balancing, lifting, carrying, pushing or pulling with the legs or feet and use of foot controls.

This section is especially important, as the physician must extract sufficient history to assess the injured worker's pre-injury functional capacity for work ~~activity~~ activities and activities of daily living. Determining the previous work capacity within the past several years best assesses this. Regular non-work activities ~~can~~ should also be taken into account to determine previous functional levels.

(2) Description of how and when the injury occurred and the type of occupational exposure.

(3) Summary of the course of treatment for the injured worker including type of treatment and response to treatment to date.

(4) Current treatment including type and frequency.

(5) Description of pertinent past medical history including previous and or subsequent injuries or illnesses, and a description of any prior neurological or musculoskeletal disabilities particularly relating to the lower extremity.

(6) Pertinent other past medical history and other contributing medical, psychological, or social concerns.

C. Current Complaints

The physician shall outline in the injured worker's words, their current complaints. This shall include all parts affected by the injury or injuries claimed, the character (quality), severity, frequency, and any radiation of symptoms, and what activities or interventions precipitate, aggravate or reduce symptoms. Delineate existing associated signs and symptoms of the injury.

NOTE: The injured worker's own description of symptoms shall be "translated" later by the physician into ratable language as defined by Packard Thurber.

Any subjective complaints regarding work activity or other activities of daily living (ADL's) shall be outlined in this section. For the foot and ankle, any functional complaints ~~in~~ such as standing, walking (over even or uneven surfaces), running, squatting, sitting, ~~knelling~~ kneeling, climbing, jumping, lifting, carrying, balancing, pushing or pulling with the legs or ~~f~~eet and the use of foot controls shall be listed in this section.

The use of assistive devices (if any) for mobility such as a wheelchair, cane, or crutches, shall be elicited and described as to type and frequency of use, as well as the need and type of any orthotic or prosthetic devices and special shoes.

D. Medical Records Reviewed

In this section, the physician shall list all records reviewed in the preparation of the report. Extractions from those records may be listed in this section or summarized in the History section of the report.

~~D.~~ E. Physical Examination of the Foot and Ankle for Disability Evaluation

(1) The physical examination shall include relevant description of body habitus, and any general observations such as a limp, obvious discomfort when standing, difficulty in transferring, etc. that may be helpful in determining previous or current functional capacity. Note any assistive devices, prosthetics, orthotics, or shoes that the injured worker uses and describe.

(1) In all measurements or observations performed, if normal, the physician may simply state "normal". Describe tests rather than just use an acronym.

(1) Inspection: The physician shall describe any skin abnormalities, surgical scars, obvious atrophy or skeletal deformities (e.g. angulation of healed fractures, varus or valgus joint deformity, or amputation). The injured parts of the foot or ankle shall be inspected for soft tissue swelling and dislocation.

(1) Amputations shall be described anatomically.

(1) Affected areas shall be palpated for tenderness. Any painful areas shall be reported. Any alterations of skin temperature or vascular status shall be noted.

(1) Joint examination

a. The physician shall assess the affected joints and compare them to the uninjured side.

a. Joint effusion, enlargement, erythema, and instability shall be described if present. Pertinent clinical tests used in joint assessment (i.e. drawer signs, Thompson's sign, etc.) shall be described as noted as normal or abnormal. If there is an abnormal range of motion that is not secondary to the injury, give an explanation for this finding.

c. Goniometric measurement is the accepted method of evaluation of range of motion for the foot and ankle. A description of goniometric methods of measurement and estimated normal values for the foot and ankle can be found in Packard Thurber, Evaluation of industrial Disability, Second Edition, Oxford University Press. The physician shall measure active range of motion of all affected joints of the foot and ankle as compared to uninjured side. Any abnormal, excessive, or limited range of motion or ankylosis shall be described.

For bilateral injuries estimate the normal range of motion. Note whether injured worker gave full effort on active range of motion and if there was any unexplained discrepancies in formally measured versus observed range of motion, or whether limitations in active range of motion was based on pain. If so, list arc range of motion precluded or inhibited by pain. If the measurement obtained were invalid based on lack of effort, so note.

(1) Leg lengths shall be measured in inches from anterior superior iliac spine (ASIS) to medial malleolus and if appropriate, other methods of leg length measurement may be included.

(1) Gait and other functional assessment: Any abnormality of gait shall be described (propulsive vs. apropulsive, angle and base of gait, etc.). Evaluate patient's ability to squat, stand, kneel, heel and toe walk, and hop on the affected foot or ankle. Note any limitations of these activities.

(1) Neurological examination of the foot or ankle shall be performed for any complaints of weakness, sensory impairment or dysesthesias. This shall include assessment of:

a. Motor examination

i. Atrophy of specific muscles or muscle groups of the lower extremities or foot should be described. General muscle bulk is assessed by measurements of the calves and thighs in inches. Circumferencial measurements of the foot and ankle should be recorded identifying the anatomic location of the measurement (e.g. midfoot, metatarsal phalangeal joints, bimalleolar). Calf measurements are taken at the point of maximum circumference. Thigh circumferences are taken

at the point one-third the distance from the upper pole of the patella to the umbilicus.

i. Muscle tone shall be described as increased, normal or decreased.

i. Muscle strength shall be graded using a scale such as those found in Appendix A. Muscle weakness due to neurologic impairment shall be differentiated by the examiner from lack of effort due to pain, disuse or lack of effort due to other causes. In cases of questionable effort, muscle weakness due to neuologic deficit can generally be corroborated by appropriate electodiagnostic testing including needle EMG and nerve conduction study performed by an appropriately qualified physician.

b. Sensory examination shall include a screening of touch and pain sensation (pinprick) in pertinent foot, ankle and lower extremity dermatomes/peripheral nerve distributions and ~~of~~ may include joint proprioception of any involved joints. Any abnormalities shall be described fully and correlated with peripheral nerve or dermatomal pattern. If the pattern of sensory impairment is nonphysiological, this should be noted

c. Deep tendon reflexes shall be obtained and graded as 0 (absent) to 4+ (hyperactive with clonus). Plantar responses and any other abnormal reflex responses shall be recorded.

d. Coordination shall be assessed if this is a presenting complaint, or if there is suspicion of foot, ankle or lower extremity motor coordination impairment. In this case, finger to nose, heel to shin and gait should be described.

(1) Screening exam of the remainder of the neurological or musculoskeletal system if there is any evidence of more widespread involvement.

F. Diagnostic Studies in Lower Extremity Disability Evaluation

(1) Order diagnostic studies only when the studies may alter the recommended plan or the evaluator's opinion regarding factors of disability. The evaluator must document the need for these additional studies.

(2) List any diagnostic procedures performed, as well as the dates and the results of the procedures. Provide the name, specialty, qualifications and opinion of any consultants.

(3) Methods of Assessment

a. Clinical diagnosis of foot and ankle problems can usually be made on history and physical examination with the help of x-rays.

b. In addition to an x-ray, testing ~~my~~ may include:

i. MRI
i. CT
ii. Bone Scan
iii. Use of mechanical devices to test strength and stability.
~~iv.~~ v. EMG/NCV tests are appropriate only if there is a suggestion of nerve damage or nerve compression.
i. Vascular studies are indicated only if there is associated vascular disruption/damage or a secondary vascular complication.
ii. Asthrogram
iii. Blood studies
iv. Ultrasound
v. Diagnostic, but not therapeutic, injectable blocks

c. ~~There are~~ Other tests ~~that~~ may be performed with proper documentation of necessity~~:~~.

~~i. Ultrasound~~
~~vi. Diagnostic, but not therapeutic, injectable blocks~~

G. DIAGNOSIS

List the relevant diagnosis(es). State if the injury is right or left sided or bilateral.

H. OPINIONS & DISCUSSION

State that the report represents your opinions and how those opinions were derived after carefully reviewing the forwarded medical information, the injured worker's subjective statements offered during consultation, and examination findings.

I. CAUSATION

State an opinion as to whether the injury or illness that led to the disability arose out of the employment (AOE).

J. PERMANENT and STATIONARY

State whether the injured worker is permanent and stationary and reasons for that opinion. The term permanent and stationary means that the injured worker has reached maximal improvement or his condition has been stationary for a reasonable period of time.

K. TEMPORARY DISABILITY

If the injured worker is not permanent and stationary, describe the current work restrictions that might allow the worker to return to work immediately, any additional treatment and the anticipated length of time necessary to achieve permanent and stationary status.

L. FACTORS OF DISABILITY

The evaluator will describe the subjective and objective components of disability**.** Do not provide a "rating" but describe the medical information in such a way as to be used by raters, judges and other concerned parties. The following information shall be included:

1. Subjective Factors of Disability

Translate the injured worker's symptoms into ratable language using the terminology found in section 9727 of title 8 of the California Code of Regulation, and are reproduced here in Appendix B. Subjective factors (symptoms) are those that cannot be directly measured or observed, such as pain, stiffness, and paresthesia. It is important to note that this is the physician's assessment of residual symptoms and is based on the examination, the physician's experience with similar injuries and his/her expert medical opinion. It is not simply a catalog of an individual's complaints, as this might inaccurately state the disability rating if the complaints are not consistent with the physician's findings. Statements in this part of the report should be consistent with the nature of the injury and with the objective findings. Work restrictions based on subjective factors that are out of proportion to objective findings require specific explanation.

The recommended description of subjective disability should include the activity which produces disabling symptoms; the intensity, frequency and duration of symptoms; a description of the activities that are precluded and those that can be performed with the symptoms; and the means necessary for relief.

2. Objective Factors of Disability

Note those finding which can be measured, observed or demonstrated on testing. They include, but are not limited to: range of motion, strength, sensation, reflexes, amputation, anatomical measurements, disfigurement, and radiographic or other diagnostic results.

Note if assistive devices, prosthetics, or orthotics are required and describe the device. Note if the device causes any limitation in motion.

3. Work Capacity

Report work restrictions for the activities the injured worker was performing at the time of the injury and for potential activities in the open labor market.

The evaluator will estimate the total or partial loss of the injured worker's pre-injury capacity to lift, walk, push, pull, climb, walk on uneven ground, squat, kneel, crouch, pivot, bear weight or other activities involving comparable physical strength. The best means is to describe the injured worker's loss of capacity, such as loss of one-quarter of his ability to lift.

Use of job history and/or description as well as other activities of daily living to estimate the pre-injury capacity, should be noted in the report to substantiate the evaluator's opinion on loss**.** Be as specific as possible, incorporating the injured worker's history, the RU-90, the DEU Form 100, and a formal job analysis, if it is available.

M. APPORTIONMENT

State if apportionment is indicated and provide reasons for the statement. Indicate in the report whether apportionment is for a pre-existing condition under Labor Code section 4750, an underlying disease process under Labor Code section 4663 or a subsequent non-industrial injury under Labor Code section 4750.5.

N. FURTHER MEDICAL CARE

Give your recommendation for current and future treatment. If the injured worker is currently receiving treatment, indicate whether the treatment is necessary to either improve or prevent deterioration of the current condition. If you believe that additional treatment is indicated to reach maximum improvement, you should explain the type of treatment, the reasons for the treatment, and the possible benefits of the treatment.

O. VOCATIONAL REHABILITATION

~~If requested~~ State if the injured employee is medically qualified for vocational rehabilitation based on your review of the job analysis.

P. AFFIRMATIONS AND SIGNATURE

The following paragraph must be included and signed and dated by the evaluator. The report must contain an original signature by the evaluator.

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and except as noted herein, that I believe it to be true."

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge.

The foregoing declaration was signed in _____ County, California

on _____(date).

_____

EVALUATOR'S SIGNATURE

Appendix A

MUSCLE GRADING CHART

Results may be reported using a verbal scale or a percentage loss of muscle strength as follows. In either case, the evaluator must still describe how a given loss of muscle strength affects the injured worker's capacity to perform work.

MUSCLE GRADATION	DESCRIPTION
5-Normal	5-complete range of motion against gravity with full resistance
4-Good	4-complete range of motion against gravity with some resistance
3-Fair	3-complete range of motion against gravity
2-Poor	2-complete range of motion with gravity eliminated
1-Trace	1-reads evidence of slight contractility, no joint motion
0 (Zero)	0-no evidence of contractility

~~EXAMPLES OF MUSCLE GRADING CHARTS~~

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~~0 (Zero)~~	~~0-no evidence of contractility~~

KENDALL	LOVETT	DESCRIPTION
100 %	Normal	The ability to hold the test position against

95 %	Normal -	gravity and maximum pressure, or the ability to move the part into test position and hold against gravity and maximum pressure
90 % 80 %	Good + Good	Same as above except holding against moderate pressure.
70 % 60 %	Good – Fair +	Same as above except holding against minimum pressure.
50 %	Fair	The ability to hold the test position against gravity, or the ability to move the part into test position and hold against gravity.
40 %	Fair -	The gradual release from test position against gravity; or the ability to move the part toward test position against gravity almost to completion, or to completion with slight assistance or the ability to complete the arc of motion with gravity lessened.

~~KENDALL~~	~~LOVETT~~	~~DESCRIPTION~~
~~30 %~~ ~~20 %~~	~~Poor +~~ ~~Poor~~	~~The ability to move the part through partial arc of motion with gravity lessened; moderate arc, 30% or poor +; small arc, 20% or poor. To avoid moving a patient into gravity lessened position, these grades may be estimated on the basis of the amount of assistance given during anti gravity test movements: A 30% or poor + muscle requires moderate assistance, a 20% or poor muscle requires more assistance~~
~~10 %~~ ~~5 %~~	~~Poor –~~ ~~Trace~~	~~In muscles that can be seen or palpated, a feeble contraction may be felt in the muscle, or the tendon may become prominent during the muscle contraction, but there is no visible movement of the part.~~
~~0 %~~	~~Gone~~	~~No contraction felt in the muscle.~~

Appendix B

Subjective disability should be described in terms of location, degree, frequency, and precipitating activity. Terms describing degree and frequency are taken to have the following meanings:

Degree:

Minimal or mild pain constitutes an annoyance, but causes no handicap in the performance of activity.

Slight pain can be tolerated but causes some handicap in the performance of precipitating activity.

Moderate pain can be tolerated but causes marked handicap in the performance of precipitating activity.

Severe pain precludes precipitating activity

Frequency:
Occasional – ~~approximately~~ 25% of the time
Intermittent – ~~approximately~~ 50% of the time
Frequent – ~~approximately~~ 75% of the time
Constant – ~~approximately~~ 90 - 100% of the time

Appendix C

DESCRIPTION OF ACTIVITIES

BALANCING:	Maintaining body equilibrium
BENDING:	Angulation from neutral position about a joint (e.g. ankle) or spine (e. g. forward)
CARRYING:	Transporting an object, usually holding it in the hands or arms or on the shoulder.
CLIMBING:	Ascending or descending ladders, stairs, scaffolding, ramps, poles, etc. . . using feet and legs and/or hands and arms.
CRAWLING:	Moving about on hands and knees and feet.

CROUCHING:	Bending body downward and forward by bending lower limbs, pelvis and spine
JUMPING:	Moving about suddenly by use of leg muscle, leaping from or onto the ground or from one object to another.
KNEELING:	Bending legs at knees to come to rest on knee or knees.
LIFTING:	Raising or lowering an object from one level to another (includes upward pulling)
PIVOTING:	Planting your foot and turning about that point.
PUSHING:	Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).
PULLING:	Exerting force upon an object so that the object moves towards the force (includes jerking).
RUNNING:	Moving in a fast pace, moving the legs rapidly so that for a moment both legs are off the ground.
SITTING:	Remaining in the normal seated position.
~~SQUATING~~ SQUATTING:	Crouching to sit on your heels, with knees bent and weight on the balls of your feet.
STANDING:	Remaining on one's feet in an upright position at a work station without moving about.
STOOPING:	Bending body downward and forward by bending spine at waist.
TURNING/ TWISTING:	Moving about a central axis, revolve or rotate.
USE FOOT CONTROLS:	Required to control a machine by use of controls.
WALKING:	Moving about at a moderate pace over even or uneven ground.